Mail To:
Wisconsin Medicaid
Prior Authorization
Suite 88
6406 Bridge Rd.
Madison, WI 53784-0088

PA/DGA

Prior Authorization
Drug/DMS Attachment
FOR ENTERAL NUTRITION PRODUCTS

1. Complete the PA/DGA.
2. Attach to the Prior Authorization Request Form (PA/RF).
3. Mail to Wisconsin Medicaid.

Recipient Information

(1)	(2)	(3)	(4)	(5)
Last Name	First Name	M.I.	Identification Number	Age

Section A — Type of Request

Indicate start date requested/date prescription filled (required) _____

(check one)

☐ This is an initial prior authorization request for this drug, for this recipient, by this provider.

☐ This is a request to renew or extend previously prior authorized therapy using this drug.
First PA # _____

☐ This is a request to change or add a new NDC number to a current valid PA.
PA# _____ NDC # to add _____

Section B — Prescription Information (complete Section B *or* attach a copy of the prescription order)

Drug Name _____ Strength _____

Quantity Ordered _____ Date order issued _____

Directions for use _____

Daily Dose _____ Refills _____

Prescriber Name _____ DEA Number _____

"Brand Medically Necessary" is handwritten by the prescriber on the prescription order: ☐ Yes ☐ No

Section C — Clinical Information

List the recipient's condition the prescribed drug is intended to treat. Include ICD-9-CM diagnosis for pharmaceutical care recipients. Include the expected length of need.

If requesting a renewal or continuation of a previous prior authorization approval, indicate any changes to the clinical condition, progress, or known results to date.

_____

_____

_____

_____

Attach another sheet if additional room is needed.

Source for Clinical Information (check one)

- ☐ This information was primarily obtained from the prescriber or prescription order.
- ☐ This information was primarily obtained from the recipient.
- ☐ This information was primarily obtained from some other source (specify): _____

Use (check one)

- ☐ Compendial standards, such as the USP-DI or drug package insert, list the intended use identified above as an accepted indication.
- ☐ Compendial standards, such as the USP-DI, list the intended use identified above as a [bracketed] accepted indication.
- ☐ Compendial standards, such as the USP-DI or drug package insert, list the intended use identified above as an unaccepted use.
- ☐ The intended use above is *not* listed in compendial standards. Peer reviewed clinical literature is attached or referenced. (Reference — include publication name, date, and page number.) _____

Dose (check one)

- ☐ The daily dose and duration are within compendial standards general prescribing or dosing limits for the indicated use.
- ☐ The daily dose and duration are *not* within compendial standards general prescribing or dosing limits for the intended use. Attach or reference peer reviewed literature which indicates this dose is appropriate, or document the medical necessity of this dosing difference. (Reference — include publication name, date, and page number.)

Additional Information Required for Enteral Nutrition Supplements

Height _____ Percentile (children only) _____

Weight _____ Percentile (children only) _____

Amount of weight loss, if any, and within what specific time span _____

(check all that apply)

- ☐ This recipient is tube fed.
- ☐ If not tube fed, number of Kcal prescribed per day _____. Percent total calories from this supplement ____%.
- ☐ This recipient can consume most normal table foods.
- ☐ This recipient can consume softened, mashed, pureed, or blenderized food.
- ☐ This recipient has a clinical condition, as indicated in Section C, which prevents him/her from consuming normal table, and softened, mashed, pureed, or blenderized foods.
- ☐ Comprehensive documentation of this recipient's condition is presented above in Section C — Clinical Information.
- ☐ This recipient is eligible for food stamps.
- ☐ This product or a similar product can be obtained from WIC.

Signature _____ Date _____

Check the appropriate box:
Please notify me of approval/denial by ☐ Fax # _____ ☐ Telephone # _____ ☐ No notice needed

The pharmacist/dispenser must review information and sign and date this form!